# *The Norwegian Mother and Child study*
## Questionnaire I

***This questionnaire will be processed by a computer. It is therefore important that you follow these instructions:***

- Please use a blue or black ballpoint pen.
- Put a cross in the box that is most relevant like this: X
- Should you put a cross in the wrong box correct it by filling in the box completely like this: ■
- In the large green boxes write a *number* or a *capital letter*

***It is important that you only write in the white area of each box like this:***

Number: Letter:

- When filling in a single figure in boxes containing two or more squares please use the square to the right. For example: 5 is written like this:
- A number of questions in this questionnaire concern the week of pregnancy. For example, fill in week 5 for something that occurred 5 weeks after your last period.
- Specific information concerning, for example, medication or profession should be written in the boxes or on the lines provided. Please write clearly in CAPITAL LETTERS.
- Remember to provide the date on which you completed the questionnaire.

***Please return the completed questionnaire in the stamped addressed envelope provided.***

Date on which the questionnaire was completed: Day, month and year (write the year with 4 numbers, ex. 2000

| Question | Answer |
|---|---|
| **Menstruation** | |
| 1. How old were you when you had your first menstrual period? | Years old |
| 2. How many days are there usually between the first day in your menstrual period and the first day in your next menstrual period? | Days |
| 3. Are you usually depressed or irritable before your period? | No/ Yes, but just slightly/ Yes, noticeably/ Yes, very much |
| 4. If yes, does this feeling disappear after you get your period? | No/ Yes |
| 5. Were your periods regular the year before you became pregnant? | No/ Yes |
| 6. During the last year before you became pregnant, did you lose your period for more than three months? | No / Yes, due to another pregnancy / Yes, for other reasons |
| 7. Date of first day of last menstrual period | day / month / year |
| 8. Did your last menstrual period come at the expected time | No/ Yes |
| 9. Are you certain about the date of first day of last menstrual period? | Certain/ Uncertain |
| 10 Describe the duration, amount of bleeding and menstrual pains of your last period | *As usual/ More than usual/ Less than usual* Duration/ Amount of bleeding/ Pain |
| **Contraception** | |
| 11. Have you/your partner at any time during the last year used the following methods to avoid becoming pregnant? *(Fill in all that apply.)* | Condom/ Diaphragm/ IUD/ Hormone IUD/ Hormone injection/ Mini pill/ Pill/ Spermicides (foam, suppositories, cream)/ Safe period/ Withdrawal/ No such methods/ Other |
| 12. If you have used the pill/mini-pill, how long have you used them? | *Pill/ Mini-pill* Less than one year/ 1-3 years/ 4-6 years/ 7-9 years/ 10 years or more |
| 13. If you have used the pill/mini-pill, how old were you when you first used it? | years old |
| 14. Were you taking the pill/mini-pill during the last 4 months before this pregnancy? | No/ Yes |
| 15. If yes, how long before your last menstrual period did you stop taking the pill/mini-pill? | weeks |
| 16. Was this pregnancy planned? | No/ Yes |
| 17. If yes, how many months did you have regular intercourse without contraception before you became pregnant? | Less than I month/ 1-2 months/ 3 months or more/ Number of months if more than 3 |
| 18. Did you become pregnant even though you or your partner used contraceptives | No (proceed to question 21) / Yes |

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| 19. If yes, which type? *(Fill in all that apply.)* | Condom/ Diaphragm/ IUD/ Hormone IUD/ Hormone injection/ Mini pill/ Pill/ Spermicides (foam, suppositories, cream)/ Safe period/ Withdrawal/ Other |
| 20. If you became pregnant while using an IUD, has it now been removed? | No / Yes |
| 21. How long have you and the baby's father had a sexual relationship? | months or years |
| 22. How often did you have sexual intercourse during the four weeks before you became pregnant and during the last four weeks? | *Before/ Now* Every day/ 5-6 times a week/ 3-4 times a week/ 1-2 times a week/ 1-2 times every two weeks/ Less than 1-2 times every 2 weeks/ Never |
| 23. Have you ever been treated for infertility? | No / Yes |
| 24. If yes, was it in connection with this pregnancy or an earlier pregnancy and what type of treatment did you have? | Fallopian tube surgery / Other surgery / Medication for endometriosis / Hormone treatment / Insemination (injection of sperm) / Test-tube method / Other |
| 25. Have you been given information about amniocentesis? | No / Yes |
| 26. What was your blood pressure at your first antenatal visit? *(Check your medical card.)* | Highest/ Lowest |
| 27. What did you weigh at the time you became pregnant and what do you weigh now (in kilograms)? | *When I became pregnant/ Now* |
| 28. How tall are you? | cm |
| 29. How tall is the baby's father | cm |
| 30. How much does the baby's father weigh? | kg |
| **Previous pregnancies** | |
| 31. Have you been pregnant before? (Include all pregnancies that ended in abortion, miscarriage or stillbirth) | No (proceed to question 36) / Yes |
| 32. If yes, fill in for all earlier pregnancies. Include all pregnancies that ended in abortion, miscarriage or stillbirth as well as ectopic pregnancies. State the year the pregnancy began, how many kilos you gained during the pregnancy and the number of months you breast-fed each baby. State whether or not you smoked during earlier pregnancies. | Pregnancy no. / Year of pregnancy / Live infant born/ Spontaneous abortion / Termination of pregnancy / Ectopic pregnancy / Week of pregnancy for abortion/still birth / No. of months breast feeding / Weight gain during pregnancy / Smoked during pregnancy |
| 33. Have you had any of the following problems during previous pregnancies? *(Fill in all that apply.)* | *No/ Yes*<br>Pelvic relaxation requiring medical leave/ Pelvic relaxation requiring bed rest/ Serious nausea and vomiting/ Eclampsia during pregnancy/ Diabetes during pregnancy/ Sugar in urine/ Problems with incontinence |
| 34. If you had pelvic relaxation in a previous pregnancy that led to bed rest or medical leave, when did the pain start? | months after start of pregnancy |
| 35. When did the pain stop? | months after pregnancy / still have pain |
| **Illnesses and health problems during this pregnancy** | |
| 36. Have you had bleeding from the vagina once or more during this pregnancy? | No / Yes |

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| 37. If yes, describe the first and last bleeding. Give the date the bleeding started, how many days the bleeding lasted and how much you bled. | *Date when bleeding started/ No. of days variation/ Amount*<br>First bleeding Last bleeding<br>day month year<br>Trace of blood/ More than just a trace/ Coagulated blood.<br>*If more than two episodes of bleeding write in the number.* |
| 38. Have you experienced any of the following illnesses or problems during this pregnancy? If you have used medication in connection with these problems give the name of the medicine, the weeks you took the medicines and how many days you took them. *(Include all types of medication, both prescription and over the counter medicines in addition to alternative and herbal remedies. Do not include vitamins and dietary supplements as these are discussed elsewhere.)* | *Illness/health problem during this pregnancy/ Use of medication*<br>*Illness/health problem/ Week of pregnancy/ Name of medicine taken/ Week of pregnancy/ No. of days taken*<br>1. Pelvic relaxation/ 2. Abdominal pain / 3. Back pain / 4. Neck and shoulder pain / 5. Nausea /6. Nausea with vomiting/ 7. Vaginal thrush / 8. Vaginal catarrh/unusual discharge/ 9. Itchy rash/ 10. Constipation/ 11. Diarrhoea/ gastric flu / 12. Unusual tiredness/sleepiness/ 13. Sleeping problems / 14. Heartburn/reflux/ 15. Oedema/ 16. Fever with rash/ 17. Fever over 38.5$^{o}$ C/ 18. Common cold/ 19. Throat infection/ 20. Sinusitis/ear infection/ 21. Influenza/ 22. Pneumonia/bronchitis/ 23. Sugar in urine/ 24. Albumin (protein) in urine |
| **Past and present illnesses and health problems** | |

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| 39. Do you have or have you had any of the following illnesses or health problems? If you have taken medication (tablets, mixtures, suppositories, inhalers, creams, etc.) in conjunction with the illness or health problem give the name(s) of the medication(s) and when you took them. | *Illness/health problem during this pregnancy/ Use of medication*<br>*Illness/health problem*<br>*Before pregnancy/ During pregnancy/ Name of medicines/ Last 6 months before pregnancy/ Pregnancy week/ 0-4 weeks/ 5-8 weeks/ 9-12 weeks/ 13+ weeks/ No. of days used*<br>**Asthma/Allergy/Skin disorders**<br>1. Asthma/ 2. Hay fever, pollen allergy/ 3. Animal hair allergy/ 4. Other allergy/ 5. Atopic dermatitis (childhood eczema) / 6. Urticaria (hives)/ 7. Psoriasis / 8. Other eczema / 9. Cold sores (herpes)/ 10. Acne/pimples (serious)/<br><br>**Diabetes**<br>11. Diabetes treated with insulin/ 12. Diabetes not treated with insulin<br><br>**Heart / Blood / Metabolism / Blood vessels**<br>13. Congenital heart defect/ 14. Other heart disease/ 15. High cholesterol/ 16. High blood pressure/ 17. Hypothyroidism or hyperthyroidism/ 18. Anaemia/low haemoglobin/ 19. B-12/folic acid insufficiency<br><br>**Gastrointestinal**<br>20. Hepatitis/jaundice/ 21. Gall stones/ 22. Duodenal/stomach ulcer/ 23. Crohn's disease/ulcerative colitis/ 24. Celiac disease / 25. Other gastro-intestinal problems<br><br>**Muscle/ Skeleton/ Connective tissue**<br>26. Rheumatoid arthritis/Bechterev's /27. Lupus (SLE)/ 28. Sciatica / 29. Myalgia<br><br>**Genital and urinary tract** |
| | 30. Ovary/fallopian tube infection/ 31. Endometriosis/ 32. Descent of the uterus/ 33. Ovarian cyst/ 34. Myoma/ 35. Cervical cell changes/ 36. Herpes/ 37. Venereal warts/ 38. Gonorrhea / 39. Chlamydia/ 40. Kidney stones/ 41. Kidney infection/ 42. Urinary tract infections/ 43. Incontinence<br><br>**Other illnesses/health problems**<br>44. Anorexia/bulimia/other eating disorders/ 45. Migraine/ 46. Other headache/ 47. Epilepsy/ 48. Multiple sclerosis/ 49. Cerebral palsy/ 50. Cancer / 51. Depression/ 52. Anxiety/ 53. Other long illnesses or health problems / Which:_____ |
| 40. Do you have a congenital deformity/ birth defect? | *No/ Yes* |
| 41. If yes, which? | |
| 42. Do your gums bleed when you brush your teeth at present? | No, rarely or never / Yes, sometimes / Yes, often / Yes, almost always |
| 43. If you had diabetes before you became pregnant, what was your last long-term blood sugar level (HbA1c) before you became pregnant? | Less that 7.5/ 7.5-12/ More than 12/ Don't know |

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| **Other medication** | |
| 44. Have you used other medication not previously mentioned? If yes, which and when did you take them? | Name of medication *(ex. Valium Rohypnol, Paracetamol)*<br>*Use of medication*<br>*Last 6 months before pregnancy/ During pregnancy weeks/ 0-4 weeks/ 5-8 weeks/ 9-12 weeks/ 13+ weeks/ No of days used* |
| **Vitamins, minerals and dietary supplements** | |
| 45. Do you take vitamins, minerals or other dietary supplements? | No (proceed to question 49) / Yes |
| 46. If yes, fill in the table below for the vitamins and minerals found in the contents list on the vitamin package/bottle. | *When did you take the supplements?*<br>*Last 6 months before pregnancy*<br>*26-9 weeks/ 8-5 weeks/ 4-0 weeks.*<br>*During pregnancy*<br>*0-4 weeks/ 5-8 weeks/ 9-12 weeks/ 13+ weeks*<br>*In this period how often did you take this?*<br>*daily/4-6 times a week/1-3 times a week*<br>1. Folic acid/ 2. Vitamins B1 (Thiamine)/ 3. B2 (Riboflavin)/ 4. B6 (Pyridoxine)/ 5. B12/ 6. Niacin/ 7. Pantothenic acid/ 8. Biotin / 9. Vitamin C/ 10. Vitamin A/ 11. Vitamin D/ 12. Vitamin E/ 13. Iron/ 14. Calcium/ 15. Iodine/ 16. Zinc/ 17. Selenium/ 18. Copper / 19. Chromium/ 20. Magnesium/ 21. Cod liver oil/ 22. Omega -3 fatty acid |
| 47. Give the complete name(s) of all vitamins and dietary supplements you take. Include alternative/herbal remedies and diet products. (*Write clearly in CAPITAL LETTERS.)* | Ex. **VITAPLEX WITH IRON** |
| 48. If you use multivitamins (with or without minerals) do these contain folic acid? | Yes / No / Don't know |
| **Civil status and education** | |
| 49. What is your civil status? | Married/ Cohabitant/ Single/ Divorced/separated/ Widow/ Other |
| 50. What education do you and the baby's father have? *(Fill in the highest level of education you have completed and current studies if you are still in school.)* | *You/ Baby's father*<br>*Completed/ Ongoing*<br>1. 9-year secondary school/ 2. 1-2 year high school / 3. Vocational high school/ 4. 3-year high school general studies, junior college/ 5. Regional technical college, 4-year university degree (Bachelor's degree, nurse, teacher, engineer)/ 6. University, technical college, more than 4 years (Master's degree, medical doctor, PhD)/ 7. Other education |

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| **Work and leisure** | |
| 51. What was your and the baby's father work situation when you became pregnant? (*Fill on one or several boxes for each.)* | *You/ Baby's father*<br>1. Student/ 2. At home/ 3. Intern/apprentice/ 4. Military service/5. Unemployed/laid off/ 6. Rehabilitation/disabled/ 7. Employed in public sector/ 8. Employed in private sector/ 9. Self-employed/ 10. Family member without steady income in family company (ex. Farming, business)/ 11. Other |

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| 52. Did you have an extra job (with or without salary) when you became pregnant? *(For example, accountant, hair dresser, singer in a dance band, club leader)* | No/ Yes, describe |
| 53. Have you been absent from work more than two weeks during this pregnancy? | No/ Yes |
| 54. Are you absent from your work at the present time? | No/ Yes |
| 55. If yes, what is the reason for your absence? *(Fill in one or several boxes.)* | Medical leave/ Leave of absence/ Sick child/ Other |
| 56. The usual number of paid working hours a week before you became pregnant and at present. | Before the pregnancy hours/ During the pregnancy hours |
| 57. Describe the type of work carried out at your and the baby's father's place of work as accurately as possible. (*Write for example, hospital department for children with cancer, body shop at a garage for diesel vehicles, farming with grain and swine, work in the home.)* | You / Baby's father |
| 58. Occupation/title at this workplace? *(Write for example, staff nurse, mechanic, foreman, lecturer, student, cleaning assistant, housewife/at home.)* | *You Baby's father* |
| 59. Indicate the appropriate answer for each of the following questions concerning your present work situation. *(Fill in only one box in each line.)* | *Yes, every day more than half of the working day/ Yes ,every day less than half of the working day/ Yes, periodically but not daily/ Seldom or never*<br>Do you sometimes have so much to do that your work situation becomes taxing?/ Do you have to turn and bend many times in the course of an hour?/ Do you work with your hands above shoulder level or higher?/ Do you work walking or standing?/ Can you choose to work a little faster some days and a little slower on other days?/ Are you subjected to a lot of uncomfortable background noise?/ Are you subjected to a lot of background noise that makes you have to raise your voice when talking to others, even at a distance of one metre? |
| 60. How do the following statements describe your work situation? *(Fill in only one box in each line.)* | *Agree/ Agree mostly/ Disagree mostly/ Disagree*<br>I have physically heavy work/ My work is very stressful / I learn a lot at work/ My work is very monotonous / My work demands a lot of me/ I am able to decide how my work is to be carried out / There is a good team spirit at my place of work / I enjoy my work |

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| 61. When are your working hours? *(Fill in one or several boxes.)* | Permanent day work / Permanent afternoon or evening work/ Permanent night work/ Shift work (day and night) or shift rotations/ No set times (extra work, extra shifts, temporary employment, etc.)/ Other |
| 62. During your pregnancy do you lift anything that weighs more than 10 k? (*10 kilos is the equivalent of a full bucket of water.)* | *At home/ At work*<br>Infrequently or never/ Yes, less than 20 times a week/Yes, more than 20 times a week/ Yes, 10-20 times a day/ Yes, more than 20 times a day |

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| 63. How often have you worked with radio transmitters or radar after becoming pregnant? | Infrequently/Never/ A few times a week/ Daily/ On average more than an hour daily |
| 64. How often do you use a cell phone? | Infrequently/Never/ A few times a week/ Daily/ On average more than an hour daily |
| 65. Do your cell phone calls last more than 15 minutes? | Never/ Infrequently/ Often |
| 66. How often do you work with a computer, laser printer or copying machine (at a distance of less than two metres) after you became pregnant? | Never/ A few times a week/ Daily/ On average more than an hour daily |
| 67. How often have you worked with x-ray equipment (at a distance of less than two metres) after you became pregnant? (*This does not include treatment as a patient*) | Never/ A few times a week/ Daily/ On average more than an hour daily |
| 68. Have you been in contact with any of the following substances either at work or in your leisure time during the last six months? *(Fill in each line.)* | *No/ Yes*<br>*If yes, number of days (daily = 180 days)/ Fill in if you have used a hood for gases or breathing protection/ Fill in if you have used protective gloves*<br>1. Lead vapors, lead dust, lead particles or lead alloys/ 2. Chrome, arsenic, cadmium or combinations of these/ 3. Gasoline or exhaust (does not apply to filling gasoline in your own car)/ 4. Mercury vapors, mercury or work with amalgam fillings (does not apply to your own dental treatment)/ 5. Disinfectants, vermin poisons/ 6. Weed killers, insecticides, fungicides/ 7. Oil-based paint/ 8. Water-based or latex paint/ 9. Paint thinner, paint-lacquer-glue remover or other solvents (ex. lynol, turpentine, toluene, carbon tetrachloride)/ 10. Industrial dyes or ink/ 11. Motor oil, lubrication oil or other types of oil/ 12. Photographic chemicals (fixatives or developers)/ 13. Substances used in welding/ 14. Substances used in soldering/ 15. Formalin/formaldehyde/ 16. Chemotherapeutic substances/ chemotherapy treatment (does not apply to your own medical treatment)/ 17. Laughing gas or other anesthetic gases (does not apply to you own treatment as a patient)/ 18. Other substances and conditions, describe:_____ |
| 69. How often have you been to a discotheque since you became pregnant? | 1-2 times a week / Less often / Never |
| 70. Are you in contact with animals either at work or in your leisure? | No / Yes |
| 71. If yes, what sort of animals and how often are you in contact with them on a weekly basis? | *Daily/ 3-6 times a week/ 1-2 times a week/ Less than once a week*<br>1. Dog/ 2. Cat/ 3. Guinea pig/ 4. Hamster/ 5. Rabbit/ 6. Canary or other bird/ 7. Aquarium fish/ 8. Cow/ 9. Pig/ 10. Sheep, goat/ 11. Horse/ 12. Poultry/ 13. Other |
| **Household conditions** | |
| 72. With whom do you live? *(Fill in one or several boxes.)* | Spouse/partner/ Parents/ Parents-in-law/ Children/ No one/ Others, describe |
| 73. How many people including you live in your home? | Number of people over 18 years/ Number of people between 12 and 18 years/ |
| | Number of people between 6 and 11 years/ Number of people under 6 years |
| 74. How many children are at nursery school? | children |
| 75. Do you or the baby's father have a mother tongue other than Norwegian? | No/ Yes |

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| 76. If yes, which language? | *You / Baby's father*<br>Sámi/ Urdu/ English/ Other/ If other, which_____ |
| 77. Do your parents or the baby's father's parents have a mother tongue other than Norwegian? | No / Yes |
| 78. If yes, which language? | *Your mother/ Your father/ Mother of the child's father/ Father of the child's father*<br>Sámi / Urdu / English / If other, which_____ |
| 79. What is your and the baby's father's yearly gross income? (*Include child support, unemployment benefits and other allowances.)* | *Your gross income/ Child's father's gross income*<br>No income/ Under 150.000 NOK/ 151.000-200.000 NOK/ 201.000-250.000 NOK/ 251.000-300.000 NOK/ 301.000-400.000 NOK/ 401.000-500.000 NOK/ Over 500.000 NOK/ Don't know |
| 80. Is it possible for your household to manage financially without your income? | No/ Yes, but with difficulty/Yes, without difficulty |
| 81. What type of housing do you live in? | Detached house/ Farm/Semidetached/ Four-flat house/ Maisonette/ Terraced flat/ Basement flat/ Apartment building/ Townhouse/tenement. Which floor?/ Other |
| 82. Has there been water damage, visible signs of fungus/mildew or a smell of mildew in your home in the past 3 months? *(Fill in one or several boxes.)* | No / Yes, water damage / Yes, signs of fungus and mould / Yes, a smell of mildew |
| 83. Where does your drinking water come from? | Public or private water supply/ Water from a local source *(ex. well)* |
| 84. How many times have you moved in the last 3 years? | times |
| 85. Has anyone in your home had influenza, a prolonged cough, childhood disease or an illness with fever and a rash after your became pregnant? | No/ Yes |
| 86. If yes, which illness | German measles/ Chicken pox/ Measles/ «4th infant disease»/ Other fever with rash/ Influenza/ Prolonged cough/ Tuberculosis/ Foot and mouth disease/ Other |
| **Habits** | |
| 87. Did your mother smoke when she was pregnant with you? | No/ Yes / Don't know |
| 88. Are you exposed to passive smoking at home? | No/ Yes |
| 89. If yes, how many hours a day are you exposed to passive smoking? | hours a day |
| 90. Are you exposed to passive smoking at work? | No/ Yes |
| 91. If yes, how many hours a day are you exposed to passive smoking? | hours a day |
| 92. Did the baby's father smoke before you became pregnant? | No/ Yes |
| 93. Does he smoke now? | No/ Yes |
| 94. Have you ever smoked? | No (proceed question 104) / Yes |
| 95. Do you smoke now (after you became pregnant)? | No/ Sometimes/ Daily / cigarettes per week / cigarettes per day |
| 96. Did you smoke during the last 3 months before you became pregnant this time? | No/ Sometimes/ Daily / cigarettes per week / cigarettes per day |

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| 97. How old were you when you started to smoke on a daily basis? | years |
| 98. Have you stopped smoking completely? | No / Yes |
| 99. If yes, how old were you when you stopped smoking? | years |
| 100. If you stopped smoking after you became pregnant, in which week of pregnancy did you stop? | week of pregnancy |
| 101. How long after you get up in the morning until you light your first cigarette? | 5 minutes/ 6-29 minutes/ 30-60 minutes/ More than one hour |
| 102. Do you smoke when you are ill? | No/ Yes |
| 103. Do you smoke more often during the first few hours after you wake up than you do during the rest of the day? | No/ Yes |
| 104. If you have used other kinds of nicotine indicate which and when you used them. | *Before pregnancy /During pregnancy*<br>Chewing tobacco/snuff / Nicotine chewing gum/ Nicotine adhesive bandage/ Nicotine inhaler |
| 105. What was your fluid consumption (number of cups/glasses) per day before and during pregnancy? (1 mug = 2 cups, 1 small plastic bottle (0.5 litre) = 4 cups, 1 large plastic bottle (1.5 litres) = 12 cups) | *Number of cups/glasses*<br>*Before pregnancy/ Now/ Decaffeinated*<br>*1.* Filter coffee/ 2. Instant coffee/ 3. Percolated coffee/ 4. Tea/ 5. Herbal tea/ 6. Coca cola/Pepsi/Diet Coke/ 7. Other sodas/ 8. Coca Cola, Pepsi light/ 9. Other diet sodas/ 10. Tap water/ 11. Bottled water<br>*Before pregnancy/ Now/ Ecological*<br>12. Nectar/squash/ 13. Diet nectar/squash/ 14. Skimmed, low fat and/or whole milk/ 15. Yogurt, all types/ 16. Yogurt with active Lactobacillus, all types/ 17. Other sour milk (kefir)/ 18. Other |
| 106. Have you used any of the following substances? | *Never/ Previously/ Last month before pregnancy/ During pregnancy*<br>1. Hash/ 2. Amphetamine/ 3. Ecstasy/ 4. Cocaine/ 5. Heroin |
| 107. Have you ever consumed alcohol? | No (proceed to question 117) /Yes |
| Alcohol units are used to compare the different types of alcoholic beverages. 1 alcohol unit (= 1.5 cl. pure alcohol) is equivalent to:<br>1 bottle/can energy drink or cider<br>1 glass (1/3 liter) of beer<br>1 wine glass red or white wine<br>1 wine glass sherry or other fortified wine<br>1 snaps glass spirits or liqueur | |
| 108. How often did you consume alcohol in the 3 months before you became pregnant and how often do you consume alcohol during the pregnancy? | *Last 3 months before pregnancy/ During pregnancy*<br>Approximately 6-7 time a week/ Approximately 4-5 times a week/ Approximately 2-3 times a week/ Approximately once a week/ Approximately 1-3 times a month/ Less than once a month/ Never |

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| 109. What type of alcohol do you usually drink? *(Fill in one or several boxes.)* | Light beer/ Beer/ Red wine/ White wine/Low alcohol sodas / Fortified wines (*sherry, port wine, Madeira)*/ Spirits (*vodka, gin, snaps, cognac, whisky, liqueur)* |
| 110. Did you drink 5 units or more at least once during the last 3 months before pregnancy or during pregnancy? | *Last 3 months before pregnancy/During pregnancy*<br>Several times per week/ Once a week/ 1-3 times a month/ Less than once a month/ Never |

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| 111. How many units of alcohol do you usually drink when you consume alcohol? | *Last 3 months before pregnancy/ During pregnancy*<br>10 or more/ 7-9/ 5-6/ 3-4/ 1-2/ Less that 1 |
| 112. How many units of alcohol do you have to drink before you feel any effect? | units |
| 113. Have other people irritated or hurt you by criticising how much you drink? | No/ Yes |
| 114. Have you ever felt that you ought to drink less alcohol? | No/ Yes |
| 115. Have you ever drunk alcohol in the morning to calm your nerves or to get rid of a hangover? | No/ Yes |
| 116. Have you ever experienced any of the following problems during the last year in relation to your alcohol consumption? | *Never / Once / Several times*<br>Argued with or had negative feelings for a family member/ Suddenly found yourself somewhere without knowing how you got there/ Been absent from work or school / Fainted or passed out suddenly / Been sad |
| **Weight and weight control** | |
| 117. Do you think you were overweight before this pregnancy? | Yes, a lot/ Yes, a little/ No |
| 118. Are you worried about putting on more weight than necessary during this pregnancy? | Yes, very worried/ Somewhat worried/ No, not especially worried |
| 119. Has anyone said that you were too thin while you felt that you were too fat during the last 2 years? | Yes, often/ Yes, occasionally/ No |
| 120. Have you ever lost control while eating and not been able to stop before you have eaten far too much? | *Last 6 months before this pregnancy/ Now*<br>No/ Infrequently/ Yes, at least once a week |
| 121. Have you ever used any of the following to control your weight? | *Last 6 months before this pregnancy/ Now*<br>*At least once a week/ Seldom/never/*<br>Vomiting/ Laxatives/ Fasting/ Hard physical exercise |
| 122. Is it important for your self-image that you maintain a certain weight? | Yes, very important/ Yes, quite important/ No, not especially important |
| **Physical activity** | |

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| 123. How often do you usually exercise at the present time? *(Fill in each line, both before and during this pregnancy.)* | *Last 3 months before this pregnancy/ During this pregnancy*<br>*Never / 1-3 times a month / Once a week / Twice a week / 3 times or more a week*<br>1. Walking/ 2. Brisk walking/ 3. Running/jogging/cross-country running/ 4. Bicycling/ 5. Training studio/weight training / 6. Special gymnastics/aerobics for pregnant women/7. Aerobics/gymnastics/dance without running and jumping/ 8. Aerobics/gymnastics with running and jumping/ 9. Dancing (swing/rock/folk)/ 10. Skiing/ 11. Team sports/ 12. Swimming/ 13. Riding/ 14. Other |
| 124. How many times a week do you do exercises for the following muscle groups? *(Fill in each line, both before and during this pregnancy.)* | *Last 3 months before pregnancy/ During pregnancy*<br>*Never / 1-3 times a month / Once a week / Twice a week / 3 times or more a week*<br>Abdominal muscles/ Back muscles /Pelvic floor muscles (muscles around the vagina, urethra, anus) |
| 125. How often are you currently so physically active in your leisure and/or at work that you get out of breath or sweat? | *Last 3 months before pregnancy During pregnancy*<br>*Leisure/ At work*<br>Never/ Less than once a week/ Once a week/ 2 times a week/ 3-4 times a week/ 5 times a week or more |

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| | Almost every day *At work / At leisure* |
| **You and your feelings** | |
| 126. Do you agree or disagree with the following statements? *(Fill in only one box in each line.)* | *Disagree completely/ Disagree/ Disagree somewhat/ Don't agree or disagree/ Agree somewhat/ Agree/ Agree completely*<br>My life is largely what I wanted it to be/ My life is very good/ I am satisfied with my life/ To date, I have achieved what is important for me in my life/ If I could start all over, there is very little I would do differently |
| 127. How do these statements describe your relationship? (*Only answer if you have a partner.*) *(Fill in only one box in each line.)* | *Agree completely/ Agree/ Agree somewhat/ Disagree somewhat/ Disagree/ Disagree completely*<br>My husband/partner and I have a close relationship/ My partner and I have problems in our relationship/ I am very happy with our relationship/ My partner is usually understanding/ I often think about ending our relationship/ I am satisfied with my relationship with my partner/ We often disagree about important decisions/ I have been lucky in my choice of a partner/ We agree about how our child should be raised/ I think my partner is satisfied with our relationship |
| 128. Do you have anyone other than your husband/partner you can ask for advice in a difficult situation? | No / Yes 1-2 people / Yes more than 2 people |
| 129. How often do you meet or talk on the telephone with your family (other than your husband/partner and children) or close friends? | Once a month or less/ 2-8 times a month/ More than twice a week |
| 130. Do you often feel lonely? | Almost never/ Infrequently/ Sometimes/ Usually/ Almost always |
| 131. Have you been bothered by any of the following during the last two weeks? *(Fill in each line.)* | *Not bothered/ A little bothered/ Quite bothered/ Very bothered*<br>Constantly frightened or anxious/ Nervous, inner turmoil/ Feeling of hopelessness with regard to the future/ Depressed, sad/ Frequently worried or uneasy |

| | |
|---|---|
| 132. Have you ever in your adult life been slapped, hit, kicked or bothered in any way physically? (*you may cross off several)* | *During this pregnancy /Last 6 months before pregnancy/ Earlier*<br>No/ Yes/ Don't remember |
| 133. Have you ever been pressured or forced to have sexual intercourse? *(Fill in one or several boxes.)* | *During this pregnancy / Last 6 months before pregnancy / Earlier*<br>No, never/ Yes, pressured/ Yes, forced with violence/ Yes, raped |
| 134. How do you feel about yourself? *(Fill in each line.)* | *Agree completely/ Agree/ Disagree/ Disagree completely*<br>I have a positive attitude toward myself/ I feel completely useless at times/ I feel that I do not have much to be proud about/ I feel that I am a valuable person, as good as anyone else |
| 135. Have you ever experienced the following for a period of 2 weeks or more? *(Fill in each line.)* | *No/ Yes*<br>Felt depressed, sad/ Had problems with appetite or eaten too much/ Been bothered by lack of energy/ Blamed yourself and felt worthless/ Had problems with concentration or had problems making decisions/ Had at least 3 of the problems named above simultaneously |
| 136. If you have had 3 or more of these problems at the same time how many weeks did the longest period last? | weeks |
| 137. Was there a particular reason for this? | No, no particular reason/ Yes *(ex. death, divorce, miscarriage, accident)* |
| **We would be grateful if you would write anything else you would like to tell us about this pregnancy or previous births/pregnancies that are not addressed in this questionnaire on the next page.** | |
| Comments | |

**Have you remembered to fill in the date on which you completed the questionnaire on page 1?**

**Thank you very much for your help!**

**Please return the completed questionnaire in the stamped addressed envelope provided.**